Statement of Insurability for Life Insurance
Instructions

1. **Employer's Name, Group #, Location/Division/Sub Group #, Class # (if applicable)**
   To be prefilled by your Employer. Any questions or concerns, please contact your Benefits Administrator.

2. **Employee & Dependent Information:**
   Please complete information in full for individuals requesting coverage i.e.; employee, spouse, children. If not requesting coverage, please leave blank.

3. **Products being Underwritten:** This section must be completed in order to process the request for coverage. This section refers to the type(s) and amount(s) of coverage you (and your dependents, if applicable) already have with your employer and any additional amounts you are requesting at this time. You may disregard any of the benefits that you are not applying for, they are not applicable.

   Amount You Already Have with Employer – Complete the Basic Life/Supplemental Life/Current Life columns if you have some level of coverage already in place with your employer's benefit plan. If you have no current coverage, just enter "0" in this column.

   Amount You're Requesting – Complete the Total Life Amount Desired and Life Amount to be Underwritten columns if you are new to this benefit coverage OR if you are requesting an additional amount of coverage above current coverage. Only include the amount above current coverage in this column if that applies to you.

   - Your Benefits Administrator may complete this section of the form for you. If he/she does, make sure to complete the check box for the reason form is being submitted at the end of the section.
   - If your Benefits Administrator does not complete this section for you, you will need to complete it.

   If you have any questions or concerns regarding the type(s) or amount(s) of coverage you already have with your employer or that you're requesting at this time, please contact your Benefits Administrator prior to submitting your request for coverage. If this information is missing or incomplete it will delay your request for coverage.

4. **Completing personal information on the form.** All questions must be answered for each individual applying for coverage. All health questions answered yes must include details of the individual's medical history where asked. If this information is missing or incomplete, the application may be returned to you for completion.

5. **Signature(s) and date(s).** The signature and sign date of both employee, and spouse if applicable, must be completed on the bottom of the Statement of Insurability form where specified. Forms with this information missing will be returned, which will delay your request for coverage.

6. **For your records.** Please make a copy of the completed form for your records. The Insurance Information Practices Notice should be reviewed and kept by you for your records.

7. **IMPORTANT! Submitting the form.** After completing, signing and dating the form, please mail, fax or email directly to the insurance company, please see below:

   UnitedHealthcare
   Group Medical Underwriting Services
   P.O. Box 17829
   Portland, ME 04112
   Fax #: 1-855-290-5224
   Email: eoi_underwriting@uhc.com

UnitedHealthcare Insurance Company
Statement of Insurability

Employer		Group #	Location
Employee Name		Employee Social Security No.	
Address		City, State, Zip	
Employee Date of Birth	Hire Date	Home Phone #	Work Phone #

Income
☐ Salaried Annual base salary ______________ ☐ Hourly Hourly rate ____________ # of hours worked ________ per week

Persons Proposed for Coverage (list Employee Information on line 1):

NAME FIRST, M.I., LAST	RELATIONSHIP TO EMPLOYEE	SEX M/F	BIRTH DATE MM/DD/YYYY	HEIGHT FT, IN	WEIGHT LBS

For life coverages, enter the dollar amount of current coverage (including any guaranteed issue amount, if applicable), the total dollar amount desired and the dollar amount of the difference between the total amount desired and the current amount which requires proof of good health at this time (i.e. needs to be medically underwritten).

	Product(s) Being Underwritten				
	Basic Life	Supplemental Life	Current Life Amount	Total Life Amount Desired	Life Amount to be Underwritten
Employee			$	$	$
Spouse	N/A		$	$	$
Dependent #1	N/A		$	$	$
Dependent # 2	N/A		$	$	$

This Statement of Insurability is being submitted due to: ☐ Initial Enrollment ☐ Late Entrant ☐ Employer Open Enrollment
☐ Increase ☐ Other. If other, please explain: ____

The following questions apply to all persons proposed for coverage

1. Note that you are not required to answer "yes" if you have only been tested for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex). Within the past 5 years has any person proposed for coverage ever been medically treated or medically diagnosed with:
   a) ☐ Yes ☐ No Diabetes or sugar, albumin or blood in the urine: If Yes, when first diagnosed? ____________________
   b) ☐ Yes ☐ No High blood pressure, chest pain, heart murmur, shortness of breath, angina or other heart or circulatory disorder?
   c) ☐ Yes ☐ No Stroke, epilepsy, fainting, dizziness, headaches or any disorder of the brain or nervous system?
   d) ☐ Yes ☐ No Tuberculosis, asthma, hay fever, lung or respiratory disorder?
   e) ☐ Yes ☐ No Stomach or duodenal ulcer, other ulcer, colitis, disorder of gall bladder, liver, stomach or intestines?
   f) ☐ Yes ☐ No Varicose veins, varicose ulcers, or phlebitis or hernia of any kind?
   g) ☐ Yes ☐ No Kidney, bladder or prostate disorder or other urinary disorder?
   h) ☐ Yes ☐ No Tumor or disease or dysfunction of the breast, reproductive organs or abnormal menstrual period?
   i) ☐ Yes ☐ No Arthritis, rheumatism or any disorder of the joints, muscles, back or bones?
   j) ☐ Yes ☐ No Cancer or tumor or ulcer of any kind, growth or cyst?
   k) ☐ Yes ☐ No Any disorder of eyes, ears, nose or throat?
   l) ☐ Yes ☐ No Alcoholism, narcotic addiction (or have you or your dependents joined any organization for alcoholism or drug abuse)?
   m) ☐ Yes ☐ No Nervous or mental disorder (including professional counseling)?
   n) ☐ Yes ☐ No Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)?

2. Has any person proposed for coverage:
   a) ☐ Yes ☐ No Had any life or health insurance declined (not applicable to Missouri residents), postponed or modified, or had a waiver or extra premium added?
   b) ☐ Yes ☐ No Been released from the military for medical reasons?
   c) ☐ Yes ☐ No Received payment for disability, illness or injury?
   d) ☐ Yes ☐ No Had a change of weight of more than 10 pounds in the last 12 months? If Yes, state name of person(s), reason(s) and amount(s) of gain/loss in Detail Section below.
3. Within the past 5 years, has any person proposed for coverage:
   a) ☐ Yes ☐ No Had a physical examination, electrocardiogram, X-ray, blood test or diagnostic test, the results of which indicate an underlying medical condition? Note that you are not required to answer this question if the testing was for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex).
   b) ☐ Yes ☐ No Had inpatient or outpatient surgery?
   c) ☐ Yes ☐ No Been advised to have surgery not yet done?
   d) ☐ Yes ☐ No Had any medical treatment, health or physical impairment, condition or congenital anomaly not mentioned above?
4. ☐ Yes ☐ No Have medications been prescribed to any person proposed for coverage for any reason in the last 12 months? If Yes, please list medication name, dose, dates used and condition used for in Detail Section below.
5. ☐ Yes ☐ No Are any persons to be covered pregnant?

   If Yes: Name of person_______________________________________

   Expected delivery date:___________________

DETAIL SECTION - GIVE FULL DETAILS FOR EACH "YES" ANSWER IN QUESTIONS 1 – 4 ABOVE IF MORE SPACE IS NEEDED, ATTACH A SEPARATE PIECE OF PAPER, SIGNED AND DATED.

Name of Person	Question No.	Dates of Treatment	Diagnosis, Degree of recovery	Name, Address, Phone # of Attending Physician

NAME, ADDRESS AND PHONE # OF PRIMARY CARE PHYSICIAN OF PERSONS PROPOSED FOR COVERAGE:

	EMPLOYEE	SPOUSE	CHILDREN
DOCTOR NAME			
STREET ADDRESS			
CITY, STATE, ZIP			
PHONE NUMBER			

AUTHORIZATION AND ACKNOWLEDGEMENT

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response must be: complete; and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. (“MIB”); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; or, other organization; institution or person; that has any records or knowledge of me or my health or that of my Dependents, to disclose the information to: the UnitedHealthcare Insurance Company; and, its affiliates (“UnitedHealthcare”). This information will be used to determine my eligibility for benefits.

I authorize UnitedHealthcare to: obtain; use; and disclose; my and my Dependent’s medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize UnitedHealthcare to disclose the information to the Policy’s administrator; or as may be required by law. I authorize UnitedHealthcare, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original. I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying UnitedHealthcare in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right UnitedHealthcare has to contest any insurance or claim under the Policy. This authorization, unless revoked earlier, expires 24 months after the date it is signed. I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

I request the indicated group coverage for myself and, if applicable, for my dependents. I have not given the agent; or, any other persons any health information not included on this form. I understand that UnitedHealthcare is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; this completed application; and, that I realize that the falsity of any statement in this application for coverage shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by UnitedHealthcare. I understand that coverage will not take effect until UnitedHealthcare grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice.

Employee Signature____Date _________________________

Spouse Signature (if applying for coverage)_______________________________Spouse SS#: __________________

Return form to:
UnitedHealthcare Insurance Company
Group Medical Underwriting Services
PO Box 17829
Portland ME 04112-8829

Fax: 1-855-290-5224
Email: eoi_underwriting@uhc.com